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ABSTRACT

A nursery program for 48 deaf children aged from 1 1/2 to 3 years required active participation of the parents. Parents selected the program, tutored their and other children, observed behavior in the nursery which included hearing children, and participated in discussion of family problems. In followup, about three-fourths of the children and of their parents were rated above average by classroom teachers of the deaf. However, these results may have been due to the passive admission procedures. Parents who were not middle class seeking or who had severe personal problems did not appear to benefit. Those who were became active lobbyists for deaf children in the state. (Author/JD)

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FINAL REPORT
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A PARENT-CENTERED NURSERY PROGRAM FOR PRE-SCHOOL DEAF CHILDREN

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David M. Luterman, D.Ed.

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INTRODUCTION

The parent of a pre-school child is with little choice the child's most important teacher. Parent education programs through group discussion and demonstration have been developed for normal children (Gabbard, 1958). A great deal of information on group parent education has come about through the efforts of the Child Study Association of America (Auerbach, 1968). Recently, interest in extending information obtained with the parents of normal children to parents of handicapped children have been attempted (Levy, 1952). Relatively little work however, has been done to directly help parents of pre-school deaf children.

The need for very early instruction of the congenitally deaf child is generally acknowledged although formal programs for the child rarely begin before the child is three years of age. Several authorities have commented that the weekly therapy session with a teacher of the deaf or speech pathologist is not an adequate substitute for the kinds of formal and informal therapy that the parent could carry on at home; consequently, several programs involving the parents of deaf children have been developed (Bennet, 1955, 1957), (Landoli, 1960), (Hayes, 1965), (Horton, 1968). Most of the programs, however, concentrate on the parents for a rather limited period of time and then focus their attention entirely on the handicapped child himself. Several view their responsibility towards the parent as mainly information giving. If, however, one accepts the assumption that the parent of the pre-school deaf child is a vital factor in the child's education, then it maybe very necessary to construct a program which trains the parent. The purpose of the present project was to establish a truly parent-centered program which would focus professional attention on the parent of the very young deaf child and regard the child for a time as the raw material to enhance parental learning. This is opposed to a child-centered program in which the child is the recepient of the professional's time and attention and the extent of parental participation is limited to an observational or passive role.

The purposes of the present project were:

1. To determine if a community such as Greater Boston could support a parent-centered program in conjunction with the child-centered programs already in existence.

2. To develop materials and procedures for a parent-centered program for pre-school children.

3. To evaluate the effectiveness of a parent-centered program on the community.

METHOD

The Program

The thrust of the program was to focus professional attention on the parent of a young deaf child for two academic semesters. Each semester a group of eight families was admitted on a two-morning-a-week basis. During the first semester, the parents observed their children in the nursery and tutoring for one of the two days and for the second day per week they attended a group discussion. During the second semester, the parents took an increasingly more active role in the nursery and therapy sessions while continuing the group discussion.

Admission to the program each semester was restricted to a group of eight parents and their hearing-impaired children who were between the ages of 18 months and 3 years at the time of enrollment. Applicants were screened by pediatric, otological, psychological, and audiological testing; all of the children ultimately selected were thought to be normal with the exception of a severe hearing impairment. Four of the children who were accepted were subsequently found to have more complicated problems in addition to the hearing impairment.

The admission procedures were entirely passive; the parents selected the program. No direct agency referral was accepted: the parent had to make the initial contact. Upon receiving the request for admission, a five page application form (Appendix A) and a brochure (Appendix B) explaining the program were sent. The application form was never followed up if it was not returned. If the parent returned the questionnaire, he was then scheduled for an interview at which time the parent education aspect of the program was emphasized and the parent was asked to make a commitment to the program philosophy. He was generally not allowed to make a decision at this time, but rather was told to call in a few days if he still wished to enroll. The pediatric, otologic, and psychological examinations were then scheduled, and again, if a parent

failed to keep any appointment without notifying the program and/or the examining agency, his application was discarded. If the parent showed the initiative to make the initial contact, kept all of his appointments and had a child who was suitable for the program, he was accepted. No qualified parent has been denied admission. Upon occasion, a parent's application was deferred to a later group if more than eight applications were received.

This passive admission procedure gave a very distinct middle class bias to the parent population: The Socio-Economic Levels of the parents ranged from upper-lower to upper-middle with no other socio-economic level represented. Approximately one-third of the parents would be classified in either the upper-lower or lower-middle class. These lower classes presented some problems which will be discussed later.

Facilities

The facilities included a spacious (20′ x 30′) room, fully equipped for nursery school, with a large one-way vision mirror and a microphone-speaker arrangement contiguous to a large observation room. Two small therapy rooms with adjacent observation booths were in close proximity to the nursery. A large conference room, located elsewhere in the building was used for the parent group meetings.

Nursery

The staff of the nursery consisted of a head teacher, trained in early childhood education, and two graduate assistants enrolled in a speech pathology and audiology curriculum. The format of the nursery was informal, with language stimulation given under natural free-play situations while the children were exploring various media. When observing the nursery, the parents were aided by other staff members who pointed out aspects of the children's behavior and the techniques of natural language stimulation being employed in the nursery. The parents completed an observation form on their own child during one-half-hour period of the morning.

At the beginning of the program the parents were given a workbook (Appendix C) which included: information about the nursery, rules and regulations, information about

deafness and observation schedules for the nursery and tutoring sessions.

Tutoring

Each nursery day the child was seen for a half-hour individual tutoring lesson which, in general, followed that of the Tracy Correspondence Course, with individual modifications. The tutors utilized materials and techniques that were well within the capabilities and budgets of the parents who were observing the tutoring and completing an observation schedule. After each session, the tutor and parent discussed the session, with emphasis placed on the therapy goals and the techniques employed to control the child's behavior. At some point during the semester (approximately 2 months after the start), the parent administered the therapy while the tutor observed. At the end of the session the tutor discussed the lesson with the parent. In general, the tutors were supportive of the parent and gave constructive criticism gently and somewhat indirectly as the parent was able to handle it.

Group Discussion

In the weekly group discussion class, the technique employed was generally nondirective, i.e. the parents were encouraged to find their own individual solution to the problems under discussion. The role of the discussion leader was to set the topic and insure that the discussion centered on the topic. Specific parental questions were seldom answered directly by the leader, but would be thrown back to the group for further discussion. No attempt was made to "lecture" to the parents, although factual information was provided to the group when necessary. Some of the topics discussed were: feelings and attitudes, goals, problems of child management, and problems of educational placement.

A technique also used in the group discussion was the "Hypothetical Families" (Luterman, 1969) (Appendix D). These were 12 problem families which were presented to the parents. The families covered such problems as feelings of guilt, disappointment, confusion, problems of child management, and problems of family relations with grandparents and siblings. Selected problems were given to the group by the discussion leader. Parents

could either talk about the family or what seemed to happen most frequently, the parents related the problem directly to themselves.

Evening Meetings

Once a month both parents attended a group meeting in the evening. There were five such meetings during the first semester. This aspect of the program was reserved for the more formal lectures which followed presentation of two of the Tracy Clinic parent-information films. Guest speakers then presented a lecture: an otologist discussed the medical aspects of deafness; a psychologist commented on emotional needs of deaf children; a representative of a school for the deaf outlined the programs available for deaf children in Massachusetts; and a demonstration lesson was taught to a class of 11 to 12 year olds from one of the local schools for the deaf. The fifth evening meeting was reserved for an evaluation of the program.

The lectures, each one following the presentation, covered the following topics: the nature of the handicap of deafness, the behavioral characteristics of a deaf child, educational facilities available for deaf children in Massachusetts and a review of the various educational philosophies. The last lecture was reserved for a discussion of common errors made by parents. This lecture of common errors was written and circulated to all parent groups. A copy of this lecture may be found in Appendix E. Once each semester, an outside invited guest, lectured to all of the parents. The lectures covered within the scope of this project were: Mr. Edward Boatner from the American School for the Deaf discussing the simultaneous method, Miss Marjorie Magner from the Clarke School for the Deaf discussed Oralism, and Mrs. Doreen Pollack from the Porter Memorial Hospital discussed the Acoupedic Approach.

Once a month, group discussions were held for fathers only. These followed the same format as the morning group discussions, but were generally of longer duration and of a more formal nature.

Nursery was held one Saturday morning exclusively for the fathers and provisions were also made for the hearing siblings to observe in the nursery.

At the completion of the first semester, the parents were given an evaluation form to complete (Appendix F).

Second Semester

During the second semester, the parents were given considerable voice in determining the topics and speakers for the morning group discussion and the evening meetings which were now joint discussion meetings with husbands and wives. Consequently, the format of the meetings varied from group to group. Some groups decided to visit the various educational facilities in the community and then report back to the rest of the members. Others invited various guest speakers such as: parents of older deaf children, deaf adolescents, school administrators, and teachers of the deaf.

On the non-discussion day, two parents were assigned to work in the nursery with the nursery teacher. The materials and goals of their nursery work were planned in conjunction with the nursery teacher the week before, and an evaluation of the parents' performance in the nursery was then one of the topics for discussion in the group meeting later that week. In later groups, two parents were assigned the responsibility of criticizing the participating parents' performance. Parents would also alternate with the tutors in giving lessons to their own child. One morning each nursery day, two mothers were given the morning off and were required to indulge in some non-deaf activity outside of the nursery. A sample schedule of the second semester may be found in Appendix G.

Working with Another Child

When the parents had begun to administer the therapy, they started with a child other than their own. Parents were paired by the staff and both parents were required to observe the child in therapy and remained for the conference with the tutor. The parent-therapist then was gradually introduced into the therapy situation, and taught several lessons to the other deaf child. This procedure was initiated toward the end of the first semester; at the beginning of the second semester, the parent began to work with his own child.

Hearing Children in the Nursery

Two hearing children, one of each sex and slightly younger in age than the deaf children were included with each group. The purpose of this procedure was to help the parents distinguish between behavior that was consistent with normal 2-year-olds and behavior that was due to deafness.

The program as it developed became analagous in many ways to a student training program, the nursery and tutoring observation and participation were the parents' practicum experience, the lectures and reading materials provided intellectual stimulation and the group discussion sessions provided the parents with an opportunity to discuss and share their experiences.

RESULTS

This report covers the first three years of the project which involved six groups of eight hearing-impaired children yielding a potential population of 48 children. Four of the children, however, have been subsequently found to have a more complicated problem than deafness, two having been diagnosed as aphasic, one as deaf with severe emotional problems and one in whom no diagnosis has yet been made. Since these children are not at this time in any program for the deaf, the follow-up results have not been included on these four and the following data has been gathered on the 44 remaining children. The mean age of the children at the time of admission was 2.5 years with a range of 1.75 years to 3.67 years. Figure one presents a composite audiogram of the children. The mean pure tone speech frequency average was 98dB ISO for the right ear and 100dB for the left ear. The etiologies of the hearing losses as reported by the parents may be found in Table I.

Table I

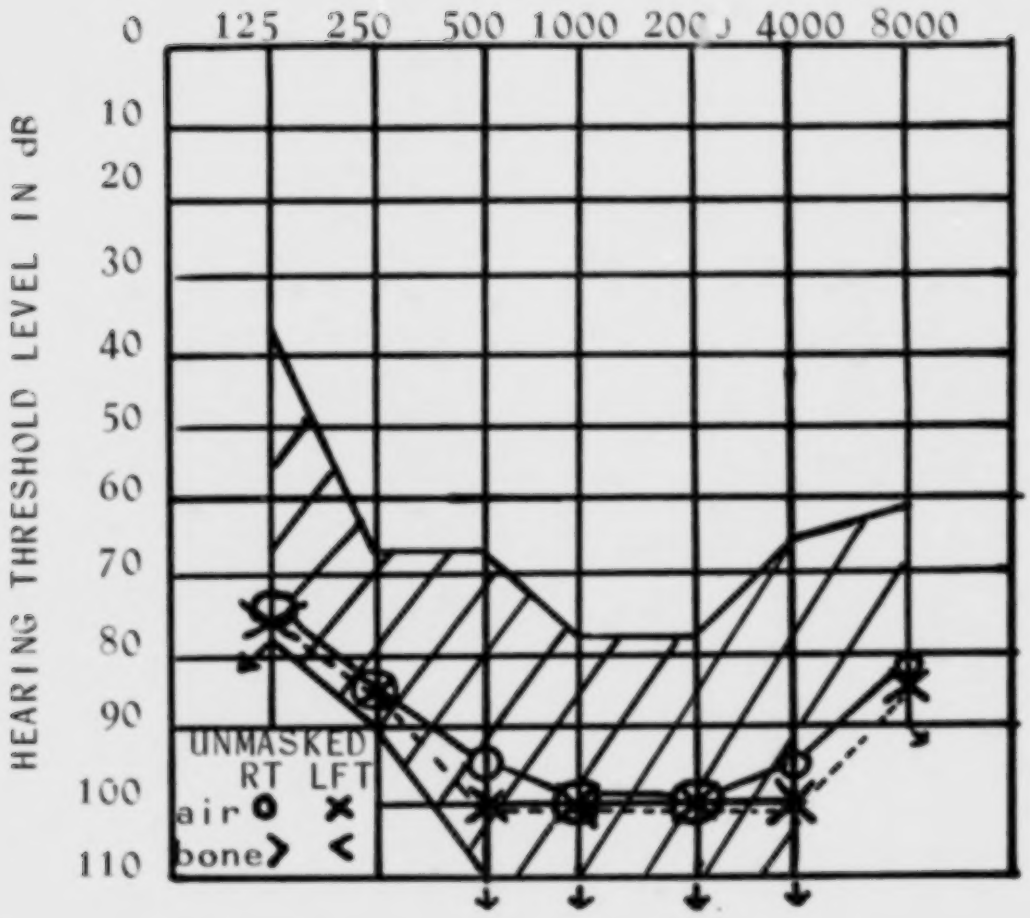
Reported Etiologies of Deaf Population

Maternal Rubella	23
Unknown	8
Meningitis	4
Genetic Factor	2
Virus	2
Prematurity	2
Birth Trauma	2
Rh Incompatibility	1

FIGURE I

COMPOSITE AUDIOGRAM

ISO 1964



It may be seen that 23 or more than half of the children were Rubella children.

Analysis of the parental evaluation sheets indicated that only 2 of the 44 parents were dissatisfied with the program and only one parent voluntarily failed to complete the program (one other parent had to move midway through the second semester). All other parents' responses were highly enthusiastic and all others completed the program. 71% of the parents felt that starting therapy with another child was a worthwhile procedure, 21% were indifferent and 8% were opposed to this procedure. On the inclusiion of the hearing child in the nursery, 70% of the parents felt that this was a valuable procedure, 18% felt it had negative value and 12% were indifferent. Responses were generally quite favorable to the "Hypothetical Family" procedure but since this procedure was used sporadically, there was no tabulation of the responses.

PARI Scales (Schaeffer and Bell, 1958) were given to the parents at the beginning and termination of the second semester. There was no statistically significant differences on any of the scale point items between pre- and post-participation scores. Moreover, there was no significant differences between selected parents' post score and parents who were enrolled in a non-parent-centered program. The results of this study have been reported and discussed by Looney (1968) in an unpublished Masters Thesis.

In May 1969, questionnaires were sent to all of the parents asking them to list the educational facility in which their child was now enrolled. The facility was then contacted and the classroom teacher was asked to rate both the parent and child. In all cases, the tabulated ratings were completed by a teacher of the deaf not associated with the parent-centered program. Table II lists the educational placements of the children.

Table II

Educational Placement as of June 1969

Public School Day Class	19
School for the Deaf, Day Basis	14
Hearing Nursery	7
Public School.	2
School for the Deaf, Residential Basis	2

It may be seen that 19 or 43% of the population are currently enrolled in Public School Day Classes.

Two of the children are enrolled in public schools with hearing children and seven are now in hearing nurseries; these latter children are in general in the more recent groups, most of whom were not sufficiently old enough for admission to a program for the deaf. Of the total population, however, 23 or 52% have had some experience in a hearing nursery school.

Table III presents the ratings of the children and of the parents by the classroom teacher. The teacher was instructed to compare the performance of the child from the parent-centered program with comparably aged deaf children on a five point rating scale ranging from poor to excellent.

It may be seen that only three of the children were rated below average and that 30 or 73% of the children rated (combining the categories of excellent and good) were rated above average by the classroom teacher, no child who participated in the program was rated poor. The three no ratings include one child not being seen by a teacher of the deaf (he was enrolled in a public school program) and two other children who were not in any program long enough for the teacher to give a rating. The parental ratings were also very similar to those of the children. It may be seen in Table III that only two of the parents were rated below average, none were rated poor and 73% of the parents were rated above average. Examination of Table III indicates that nearly 75% of the parents and the children were rated above average. The implications of these findings will be discussed in the next chapter.

DISCUSSION

The results of the follow-up study would indicate that alumni of the parent-centered program, both children and adults, are generally rated above average when compared to non-alumni by classroom teachers of the deaf. The selection procedures used of allowing the parent to select the program, however, strongly biased the sample of parents and children, and to conclude that the program was responsible for the superior performance is therefore not scientifically tenable. All of the children were

Table III

Evaluation of Children and Parents

By Classroom Teacher

Children		Parents	
Excellent	11	Excellent	18
Good	19	Good	12
Average	8	Average	9
Below Average	3	Below Average	2
Poor	0	Poor	0
No Rating	3	No Rating	3

selected on the basis of being deaf but otherwise normal (the four children who had more complicated problems were not included in the data) and the parents themselves tended to be middle class and somewhat aggressive just in locating and obtaining admission to the program. All of the parents also held education as a positive value. A sample of parents such as these are likely to yield a population of above average children and might very well be rated superior by teachers of the deaf without their ever having had the benefit of a parent-centered program.

In order to determine if a parent-centered nursery can yield deaf children with better communicative skills than a child-centered program of comparable scope, it would be necessary to have a matched group design or random sampling study. The limited number of deaf children available in the population, however precludes such an experimental design in one geographical area. It might be possible though to compare children from different geographical areas on specific speech and language tasks at some later time when the children are of sufficient age to yield adequate speech and language data. For the time being, however, one must be content with evaluating the program mainly on the basis of observational and anecdotal data.

Based on staff observations and parental reports, there are areas in which the program appears to benefit all the parents. Because of a lack of adequate measures no scientific documentation has been possible.

The Initial Confusion

By the time the parent entered the program he had generally met a large array of professionals and had been given conflicting advice and information, but did not have the time to reflect and absorb the information provided. The program, by providing a consistent point of view and allowing the parents ample opportunity to discuss their conceptions and misconceptions, appeared to help the parents resolve a great deal of the confusion. Another source of confusion lies in the feelings of guilt, embarrassment, and fear that parents bring to the learning situation. Because they were allowed to discuss their feelings and helped to accept them, the parents seemed to be better able to organize their behavior and thus cope with the problem of managing their child.

Getting the Problem into Perspective

Related to the confusion is the feeling of being overwhelmed by the extent of the problem. This is translated into a very tense parent, who, when viewing her deaf child, tends to see the deafness and not the child. Problems are not overwhelming if one is given the feeling that he can do something about them. Having the parent participate actively in the therapy helps to overcome the feelings of helplessness.

By meeting with other parents and thereby losing the feelings of being alone with their problem; by discussing the problems involved in having a deaf child in the family; and because of their contact with the matter-of-fact attitude of the staff, the parents begin to relax. As their tensions decreased, the parents seemed to be better able to meet the needs of their deaf children, and they can, as one parent expressed it, begin to "enjoy their children now." All of the parents felt that the group experience was very helpful.

Speech verses Language

One of the fundamental problems parents encounter comes from the fact that they fail to recognize that the deaf child is primarily a language-handicapped child. The very emphasis placed by the staff on the difference between speech and language, and the reciprocal nature of both, helped the parent to become language oriented. The inclusion of the hearing children seemed to help the parent; the parent was able just to see how much more the hearing child is able to understand their speech and second, the time lag between receptive comprehension and expressive speech. The hearing child also enables the parent to distinguish between behavior due to deafness and behavior due to developmental needs so that concern shifts from getting the child to speak to the more commendable approach of helping the child to understand.

The Parent As An Activist

Parents of handicapped children in an educational program tend to move through three stages: first, concern for themselves; second, concern for their child; and third, concern for all similarly handicapped children.

The measure of success of this program, therefore, can be in terms of the degree of parental involvement in promoting help for all deaf children. To date, this involvement in Massachusetts has been considerable. The alumni of the parent-centered program infiltrated an existing organization of parents which had been functioning mainly as a social organization for parents of deaf children, and transformed it into a political pressure group and an educational program. In rapid order the parents caused legislation to be passed making day classes for the hearing-impaired children mandatory in any town where there are five or more deaf children, conducted a census of deaf children in the Commonwealth, pressured the Department of Special Education to increase its allotment of funds to the deaf sector which has resulted in the hiring of more supervisors and increased services for the hearing-impaired, and created a Deaf Advisory Council which has been meeting regularly to discuss and recommend to the State Board of Education a comprehensive plan for hearing-impaired children in the Commonwealth. Current plans include the publishing of a Directory of Services, regional educational groups, and the establishment and participation in neonatal screening programs. Almost all of the executive offices of the organization are alumni of the parent-centered program. In September 1969, an article appeared in the Boston Globe quoting a pediatrician talking about the Massachusetts Parents Association as saying: "We owe these parents enormous credit for showing what the professionals should do. No community has so suddenly mobilized a whole program; town after town kicked off investigations. They took a cnesus of cases, they alerted pediatricians, teachers, and administrators. These parents were a revelation to me; they opened new avenues for research by their activities undertaken in the healthiest possible way."

Parent power is a very potent community resource; it must be nurtured and developed. No one will work longer hours for less pay than the parent of a handicapped child when his child is involved. And although the program only directly affected 48 children, all of the hearing-impaired children in the Commonwealth of Massachusetts have benefited to some extent from this program. There appears to be a huge multiplier effect from a parent education program.

There were several problems that consistenly occurred. A major difficulty was in orienting the staff to the

parent-centered concept of the program. Most academic training centers for teachers concentrate on the child with relatively little emphasis given to the non-communicatively handicapped parent. Consequently, the initial concern of the therapist was the child and the child's functioning instead of the parent and the parent's understanding of the child's functioning. It took considerable effort to alter the tutors' child-centered orientation. In staff meetings, for example, the therapists would always be asked how the parent was progressing and were not permitted to talk about the child until after they had discussed the parent: a technique which helped the therapist to become more parent-oriented.

It was also very difficult to maintain the parent-orientation over the course of the program. One must be willing, at times, to have the child suffer temporarily, if it furthers the parents' education. It was very difficult, for example, for the therapist to watch a parent fumble through a lesson that the therapist could give much more efficiently. Consequently, at times the therapist would want to jump in, which would be quite devastating to the parent's confidence. There were times also when the therapists were invited to participate in the parents' discussion group and not give any lessons that morning. The lessons that the therapists gave during the parent observation mornings were geared to the parents' capacity to understand and profit from the demonstration, and might stop even if the child wanted to continue. It is perhaps a mistake to try to append a parent education program on an existing child-centered program; one is so very easily seduced by the child that the parent is left far behind in his comprehension of the theraputic situation.

The parents, themselves, had difficulty understanding the parent-orientation. Despite the care that was taken in the initial interview to explain the underlying concept of the program, the parent rarely understood the goals of the program until much later. Parents were permitted and at times encouraged to enroll simultaneously with their enrollment in the parent program in an existing child-centered program in the community. A crisis would generally ensue when a parent compared therapists and found the parent-centered therapist seemed to be progressing slower than the child-centered therapist. It was at this time that the concept of the program was re-explained

and finally understood by most parents. Some parents never seemed to understand the goal of the program, but attended because they felt their child was being helped although they did not seem to personally benefit from the program.

It was generally the observation of the staff that the written material had very little value in promoting parent education. The parents were given the workbook (see Appendix C) but they frequently would ask questions that were quite adequately answered in the workbook indicating that they had not absorbed the material. Learning seemed to proceed best from the parents' direct participation and their being provided ample time to discuss their behavior in an accepting atmosphere.

One danger in the program was the tendency of the parent to become dependent on the staff; graduation was always a very painful time for all concerned. Parents tended to look for reassurance and hoped that the staff would make the decisions about their children for them and at times they would refuse to believe that the program would end. The goal of the program was to develop self-confidence in the parents so that they might be able to make decisions based on the accumulation of data and a reasonably objective assessment of their child's capabilities. It was therefore, very important that the staff refrain from making their decisions as it only would foster greater dependency and less self-confidence. It was also very important that the parent be given a great deal of control in the format and structure of his own learning experiences. The program was kept very flexible and some parents who wanted more therapy experience were given it while others who wished to observe more were also allowed to do so. Parental groups were encouraged to make decisions about how frequently they would like to meet for discussion and evening meetings and were given the responsibility for planning an agenda for the meetings.

The self-confidence generated by graduates of the program has sometimes led to problems with the more traditional child-centered programs in the community. Parents can become extremely critical and demanding; administrators in these other programs sometimes had difficulty coping with this more militant parent. At times, this led to difficulties between program administrators, but as the

professionals in the community became more acclimated to these parents and appreciative of their efforts to work with the professionals, relationships between programs have become significantly better. The parent-centered program is now quite compatible with existing programs in the community and child-centered programs have been a frequent source of referrals.

One of the most fundamental problems was the middle-class orientation and values of the staff as opposed to the diverse bakcgrounds of the parents; this problem occurred between the middle-class staff and the relatively few lower-class parents who found their way into the program. Because of this communication problem, parents from lower socio-economic backgrounds would at times be disdainful of some of the ideas discussed; e.g. the Tracy Information Films depicting the progress of a family with one child living in their own home. It becomes very difficult for the middle-class tutor to communicate meaningful advice to the lower-class parent or at times to communicate effectively with the parent. For example, one tutor wanted a parent to write a lesson plan for the next week's lesson. The mother did not do this and finally admitted under pressure that she could not write.

Parents who were experiencing a great deal of personal difficulties also did not seem to benefit from the program. So much of their energy seemed to be devoted to solving these other problems that little energy was left to devote to the problem of deafness. In particular this seemed to occur with several parents undergoing marital problems. It is doubtful how much these parents were able to obtain from our overall program. While they tended to be very appreciative of the staff's efforts on their behalf, it was the staff's impression that their behavior regarding their deaf child was not materially affected by the program.

The lower-class parents were the parents who generally regarded the program as a child-centered program and had very little to contribute to group discussion or the operations of the program. It did not seem to be a matter merely of socio-economic status but rather of orientation. Some lower-class parents (on socio-economic scales) who were middle-class seeking were generally very active members of the program, and

contributed a great deal to the group. It appears then that parents who have extensive personal problems and parents who are mired in poverty do not seem able to benefit from a parent-centered program to any large extent. Any community must provide a multiplicity of programs for those parents who are not capable or are unwilling to benefit from a parent-centered program. Some parents, for example, would need a home visitation program while others would probably profit best from an intensive child-centered program. It is the responsibility of professionals to insure that the community does provide a variety of suitable programs for the young deaf child. It would be a mistake to assume that all parents would benefit from a parent-centered program, but this is not to say that parent education is not a necessary part of any program.

CONCLUSIONS AND IMPLICATIONS

I. The parent-centered program appears to help create a very active community minded parent who works very hard for the establishment of new programs to help all deaf children. As such, the parent-centered program has considerable community impact.

II. Parent education appears to be enhanced by the following procedures:

A. Including hearing children with deaf children in the nursery setting.

B. Allowing the parent to initiate therapy with a deaf child other than her own.

C. Limited use of written and lecture materials and maximum practicum and discussion opportunities.

D. Use of a self-selecting admission procedure.

E. Use of the "Hypothetical Families" in promoting group discussion.

F. Allowing parents control and design of the program.

III. Because of the lack of a control group and the passive admission procedures employed which yielded a skewed distribution of parents it is not possible to conclude that the superior performance of alumni of the parent-centered program was due to their exposure to the parent-centered program. Nevertheless, sufficient changes in social and communication skills

were noted by parents and staff to conclude that the program was of benefit to the children.

IV. Parents who are not middle-class seeking and parents with severe personal problems do not appear to benefit from a parent-centered program as it was constituted. It has been suggested that the community provide a variety of programs to accomodate all parents.

Recommendations

I. The Federal Government should assist in the establishment of more parent-centered programs throughout the United States; because of the limited population of deaf children available in a population these programs will have to be located in large metropolitan areas. Programs should first be formed with Federal assistance and then after they are established, they should receive local support.

II. Teacher Training Programs should be encouraged to include more academic preparation and practicum experience in parent education for the teacher in training.

III. The Federal Government should sponsor Regional Workshops for inservice training of teachers in parent education techniques.

IV. Schools should be encouraged to include parents in the planning and execution of the educational program for the child.

V. Research needs to be directed towards the development of communication norms for pre-school deaf children and tests to assess the communicative potential of hearing-impaired pre-schoolers.

SUMMARY

This report has described a nursery program for the parents of very young hearing-impaired children. The program was centered around the parent and required the very active participation of the parent in all phases of the program. Groups of eight families were enrolled each semester and families remained in the program for two semesters. Admission was restricted to families

with children between the ages of 18 months and 3 years of age who had children who were deaf but otherwise normal. Admission procedures were entirely passive; the parent selected the program. One of the techniques used to provide the parent with a meaningful educational experience was having the parents administer lessons to their child under the supervision of a tutor. This was found to be accomplished best when the parent began the therapy with a child other than her own. Another procedure employed was including hearing children in the nursery situation to enable the parents to distinguish between behavior dur to deafness and behavior due to developmental needs. Another procedure involved the use of "Hypothetical Families" during parent discussions.

Results of the follow-up of the graduates indicated that nearly three-quarters of the children and three-quarters of the parents were rated above average by classroom teachers of the deaf. The very skewed nursery population, however, precluded the conclusion that the nursery was responsible for the superior performance of the alumni. It seemed rather that potentially good parents were attracted to the program; nearly all parents who attended felt the experience benefitted them greatly.

Alumni of the program became very active members of a parent association which was responsible for establishing legislation benefitting all deaf children in the Commonwealth. And the socially active parent seemed to be a by-product of the nursery program.

Several problems were noted, in particular the difficulty in establishing the parent-orientation concept among the staff and the parents themselves. Other problems noted were the middle-class orientation of the staff and consequently the difficulty of lower-class parents to benefit from the procedures employed. Parents with severe personal problems did not appear to benefit either from the program. A general problem of a lack of adequate speech and language norms for pre-school hearing-impaired children was noted also.

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NURSERY APPLICATION FORM

Appendix A

PARENT RELEASE FORM

I understand that the information contained in these forms and in the Clinic's reports may be transmitted by the Audiology Department of the Robbins Speech and Hearing Clinic to educational and medical agencies and individuals, in cases where such exchange of information will be beneficial to the child.

I further grant permission for the Audiology Department of the Robbins Speech and Hearing Clinic to obtain medical and educational data which will assist the Clinic in its services to my child.

Date_____SIGNED_____

AUDIOLOGY DEPARTMENT
ROBBINS SPEECH AND HEARING CLINIC

CONFIDENTIAL FOR
PROFESSIONAL USE
DATE_____

Mother's Name_____Birthdate_____
Address_____ Phone_____
No. Street City State Area Code
Last grade of education completed_____occupation_____
Special training_____

Father's Name_____Birthdate_____
Last grade of education completed_____occupation_____
Special training_____Military Status_____

Marital status: Living together__separated__divorced_____
deceased_____date of marriage_____
Description of home:own__rent__single or multiple dwelling__
No. of available bedrooms_____play space_____
What is the distance from home to the clinic?_____
Adults living in home other than immediate family_____

CHILD'S NAME_____Birthdate_____
Is child either adopted or a foster child?_____
What school, if any, does child attend?_____
Hospital where child was born_____
What is the cause of your child's deafness?_____
List all children in family in order of birth including deceased:

Name	Birthdate	Name	Birthdate
Name	Birthdate	Name	Birthdate
Name	Birthdate	Name	Birthdate

Who referred you to the Clinic?_____
Give names and addresses of doctors, teachers, or other persons whom you have consulted about your child:

1)_____
Name Address Date
What were you told?_____
_____

2)._____
Name Address Date
What were you told?_____
_____

CONFIDENTIAL - FOR PROFESSIONAL USE ONLY

CHILD'S NAME_____
Birthdate_____

HEARING INFORMATION

General Information

At what age did you first suspect that your child had a hearing loss?_____

What behavior led you to suspect this? Describe in full____
_____

At present, in his environment,what sounds do you think that your child hears? List them:(doorbell,airplane,dog bark, etc.)
_____
_____

Health History

List any diseases, injuries, or illnesses your child has had and age at which suffered:_____
_____
_____

Does this child have a handicap other than a hearing loss?___
Describe_____

Speech History

Does your child talk? Describe by giving examples of noises, words, or sentences he says:_____
_____

How do you communicate ideas or requests to your child?_____
_____

Is your child wearing a hearing aid?___Make_____Ear_____
Length of time_____Any problems in accepting hearing aid?
_____

Family Health Information

Did you have any illnesses during your pregnancy? Describe the type of illness and the month of pregnancy in which it occurred:
_____
_____

What is your RH blood type (mother's)?_____
Is there deafness in any other member of your family?_____
Describe_____
_____

Is there any other member of the family with a handicap?_____
Describe_____
What language or languages are spoken in your home?_____

Self-Help: Does your child try to dress himself with help_____
Can your child wash and dry his hands and face?_____Does he feed himself?_____ In your opinion, is he or she self-reliant_____dependent_____
Social: Does the child play often with other children?_____
Is he very shy with other children?_____Are you able to leave your child with a sitter?_____
Play: Please list the child's favorite playthings or activities:
_____
_____
_____
Emotional: What does the child do to get his way?_____
_____
_____
Does he have any particular fears? If so describe_____
_____
_____
Is he subjected to much testing?_____By whom?_____
How much does he suck his thumb?_____Any nail biting?__
Vomiting in an emotional situation_____
Is he more than normally active?_____Destructive_____
Unusually passive_____
Management:
Who is responsible for the child's discipline?_____
Have you found him easy to discipline?_____
What means do you use to control your child?_____
At what age did you (or would you) expect him to be independent in toilet training?_____

What things does the child do well?_____
_____
_____
What things worry you most about this child?_____
_____
_____

GENERAL DEVELOPMENTAL RECORD OF PRESCHOOL CHILD

Child's Name_____

Date_____

BIRTH

Health of mother during pregnancy _____

Birth: full term_____premature_____overdue_____

Delivery: duration of labor____spontaneous onset_____induced__

Birth: normal___Caesarian_____forceps_____head injuries___

Condition of baby immediately following birth_____

Was there difficulty establishing first feedings?_____

Was the baby energetic_____average_____inactive_____

DEVELOPMENT

Age of sitting up alone _____

Age of crawling____First step_____Age of walking alone_____

Has the child's development been more rapid___slower____
average_____than other children?

Is the child's appetite generally good____foods dislike_____
_____What do you do when foods are refused_____
_____Allergies_____

What is the child's bedtime?_____Is there a daily nap?_____

Does your child go to bed willingly and sleep well____If not, describe the trouble_____

Has the child his own bed____his own room____sleeps in room with_____

NURSERY BROCHURE

Appendix B

To the right, a parent learns how to work with her own child under the guidance of qualified therapists.

Enrollment

Enrollment is limited to parents with a child who is from 18 months to three years of age, and whose only handicap is deafness. The Nursery is located within the Robbins Speech and Hearing Center of Emerson College at 168 Beacon St., Boston. The facilities include a large, fully equipped nursery room, two tutoring rooms, and two observation rooms.

Workings of the Program

A maximum of eight families will be enrolled each semester. They will attend two mornings a week for two academic semesters. One morning is devoted to teaching the parents how to work with their own child through observation and practice under the guidance of qualified therapists. Emphasis is on adaption of therapeutic techniques to the individual child's needs, abilities, and interests. The second morning is reserved for a group class of parents while the children are again in the nursery and individual therapy sessions. During these classes, the parents discuss problems of managing a deaf child and help each other to find satisfactory solutions for them. The parent is responsible for the planning and execution of a lesson under the direct supervision of the therapist. There are also evening meetings once-a-month for fathers only, and one meeting a month when informative films are shown, and guest speakers are invited such as otologists, psychologists,educators and others from related fields.

Fees

There are no fees for any of the services offered by the Nursery. Parents are required, however, to participate fully in the program. For further information call KEnmore 6-7255.

THE THAYER LINDSLEY PARENT - CENTERED NURSERY FOR PRE - SCHOOL DEAF CHILDREN

at the Robbins Speech and Hearing Center, Emerson College, 168 Beacon Street, Boston, Massachusetts 02116

NURSERY WORKBOOK

Appendix C

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

- THE THAYER LINDSLEY PARENT-CENTERED NURSERY -

FOR PRE-SCHOOL DEAF CHILDREN AND

THEIR FAMILIES

ROBBINS SPEECH AND HEARING CENTER

OF

EMERSON COLLEGE

168 Beacon Street
Boston, Massachusetts 02116

Telephone - KEnmore 6-7255

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

Grant us the ability to change what can be changed, the strength to accept what cannot be changed, and the wisdom to know the difference.

- CALENDAR - FALL SEMESTER -

Monday, September 11
Wednesday, September 13 — "Orientation Days" - by appointment

The nursery will meet every Monday and Wednesday thereafter from 9:30 to 11:30 with the exception of:

Wednesday, November 1
Christmas vacation - December 18, 20, 25, 28 and January 1. Nursery school resumes on Wednesday, Jan 1.

The last day of nursery school this semester will be Wednesday, January 17.

Conferences will be by appointment during the week of January 22.

EVENING MEETINGS

The meetings are held in the second-floor classroom at 168 Beacon Street and begin at 7:30 p.m.

Thursday, September 21 . . . . . Tracy films 1 & 2, and lecture
Tuesday, September 26 . . . . . Fathers' Discussion Group

Thursday, October 19 . . . . . Tracy films 3 & 4, and lecture
Tuesday, October 24 . . . . . Fathers' Discussion Group

Thursday, November 16 . . . . . Tracy films 5 & 6, and lecture
Tuesday, November 21 . . . . . Fathers' Discussion Group

Thursday, December 7 . . . . . Tracy films 7 & 8, and lecture
Tuesday, December 12 . . . . . Fathers' Discussion Group

Thursday, January 18 . . . . . Film 9, and final discussion

If there is any doubt about whether or not a meeting will be held because of weather, etc. please call 536-7255.

REGULATIONS

1. If for any reason you are not able to attend on any day, please call (536-7255) prior to 9:30 a.m. If your child shows any signs of illness, he should be kept home. If, however, attendance is poor, you will not be able to continue in the program.

2. Be on time! 9:30 a.m. Mondays and Wednesdays

3. When you arrive, take off your child's outer clothing and escort him to the nursery. The nursery personnel will tell you when to depart. Make your departure as quickly and firmly as possible. Do not be distressed if your child cries at first.

4. Do not re-enter the nursery unless specifically asked to do so by the nursery personnel.

5. Unfortunately, we have no facilities for caring for children other than those enrolled in the nursery. Therefore, other children may not be brought to nursery school.

6. Fathers' discussion meeting will only be held if four or more fathers are able to attend. Please call (536-7255) prior to noon on the day of the meeting if you know you will be unable to attend.

7. Hearing aids must be worn and in optimum working condition everyday.

"You can teach a student a lesson for a day;
but if you can teach him to learn by creating curiosity,
he will continue the learning process as long as he lives."

Clay P. Bedford

BIBLIOGRAPHY

It is suggested that parents subscribe to "The Volta Review." It is a magazine which is published monthly, except July and August, by the Alexander Graham Bell Association for the Deaf, Inc., 1537 35th St., N.W., Washington, D.C. 20007. The cost is $12.00 per year.

Applications for the Massachusetts Parents Association (for parents of hearing impaired children) may be obtained from the secretary of the organization: Mr. Youngdahl, 21 Country Club Drive, Walpole, Massachusetts.

The books listed below are available in some libraries, as well as in the "book corner" in the conference room where the discussion meetings are held. If you borrow a book, please sign for it on the form provided.

Hearing and Deafness: A Guide for Laymen, edited by Hallowell Davis and S. Richard Silverman. Written in nontechnical language, about the nature of hearing and the problems of deafness.

The Conquest of Deafness, by Ruth Bender. A history of the education of the deaf.

Natural Language for Deaf Children, by Mildred A. Groht. A method of teaching which gives natural language to deaf pupils.

Understand Those Feelings by Eugene McDonald, Written to help those who work with, or who are parents of handicapped children.

Our Deaf Children, by Freddie Bloom, the mother of a deaf child.

The following questions are designed to help you observe your child in the therapy session. They are to serve as a guide to help you complete the observation form.

1. Does your child seem to hear better with his hearing aid than without it?

2. Does he respond to the presence of sound in anyway? By turning his head? By looking for the sound? By touching his ears?

3. Does he seem to respond better if the sound source is close to him? At what distance does he cease to respond?

4. Does he turn appropriately to where the sound is coming from?

5. Does he seem to know that a sound has stopped?

6. Can he tell the difference between two sounds(bell & drum, etc.)?

7. Does he respond to voice sounds? By turning his head? By stopping what he is doing? By looking up at the face and lips to see from where the sound is coming? By imitating what has been said-not necessarily exactly,i.e., number of syllables, stress or inflection pattern?

8. Has he learned to respond to a command?(i.e., will he wait until he hears your voice before performing an activity such as making a car go, etc.)

9. Does he recognize his name?

10. Does he understand simple nouns(ball,airplane,mama,daddy, car, etc.)?

11. Can he respond to directions indicating understanding of a situational kind rather than a specific kind?(i.e.,"open the door" when it is time to leave the therapy room and he is standing facing the door).

12. Does he vocalize spontaneously? What sound? In what situations?

13. Does he attempt to imitate vocalizations without being asked to do so? Will he vocalize upon stimulation? What kinds of stimulation?

14. Does he use vocalization in indicating his desires? Does he vocalize when angry? When pleased?

15. Does he use any recognizable words appropriately and regularly?

16. Does he cooperate willingly in most activities?

17. How does he respond to limits being placed on his behavior?

THERAPY OBSERVATION FORM

date_____

tutor_____

What is the goal(s) of the lesson:

How did the child respond to the activity:

Questions for the tutor:

Comments:

NURSERY POLICY

Children are stopped when they hurt or disturb others, endanger their own health and safety, or damage equipment. Since the children must adjust to many new adults and situations during their semester with us, it is mandatory that we all follow these same policies in guidance in the nursery; we urge you, however, to save any differences of opinion for group discussion or individual conference as we appreciate hearing new ideas.

*Foster independence and creativity.

*Whenever possible, divert the child and substitute an acceptable activity for an undesirable one.

*Encourage the child to put equipment back after using it.

*Do not laugh <u>at</u> a child or talk <u>about</u> him in his presence.

OBSERVATION

Some aspects to consider when observing the nursery are:

Equipment used and length of time.

Muscles in use and how well.

Children played with and kinds of communication.

General interests and adjustment to nursery.

Reaction to stress or conflict.

N.B. Note particularly the "Word for the Week." Notice the activities that are being used to present the word to the children, and notice how the word is used in spontaneous situations.

NURSERY OBSERVATION FORM Date_____

Word for the Week_____

Some techniques used to demonstrate the word:

Child's reactions and behavior today:

Questions and Comments:

POINTERS IN LESSON PLANNING

1. Plan lesson in advance. Know what your goals are.

2. Vary lesson. Don't always use same activity or same type of activity.

3. Don't force your child. If he does not want to do what you have planned, change; be flexible.

4. Stay Calm!

5. Demonstrate carefully and as often as necessary what you want your child to do. Don't confuse your child by not being clear in your goals.

6. Always talk in a very natural way, using sentences.

7. There will be good <u>and</u> bad days.

8. Keep notes on what you do and how your child reacts.

SOME FACTS ABOUT DEAFNESS

1. Despite recent medical and surgical advances, most forms of deafness are not medically correctable. It is a problem of education. Defects in the inner ear involving the nerve of hearing are not medically correctable, and almost all deaf children have this form of damage.

2. Because of the inadequate language, deafness is educationally handicapping. Deaf children are generally two to three years behind hearing children in school subjects. Recent studies (1964) indicate that the average 18 year-old deaf child is reading on a 5.8 grade level.

3. Because deafness involves reduced communication skills, it has a major effect on the social, personality and vocational development of deaf children.

4. While there are many different philosophies about educating deaf children, all educators agree on the need for early detection, early exposure to amplification, and early therapy. In general, the earlier, the better.

5. At the present time, there are estimated to be approximately 1,000 deaf children of school age in Massachusetts. Because of a German measles epidemic in 1963-64, there will be a significant increase in the number of deaf children in Massachusetts schools in subsequent years.

6. There are four schools for the deaf in Massachusetts: The Horace Mann School in Boston; Beverly School for the Deaf in Beverly; Boston School for the Deaf in Randolph; and Clarke School for the Deaf in Northampton. These schools go only to the eighth grade. With the exception of the Horace Mann School, they have no programs for children under age 4. There are nursery schools for deaf children in Massachusetts which are supported by the Department of Public Health.

7. All the schools for the deaf in Massachusetts are oral. Oralism tries to have deaf children learn to speak. Deaf children can be taught to speak. Before a child can learn to speak, however, he must <u>understand</u> the speech that is spoken to him.

8. A hearing aid cannot "correct" a hearing loss the way eyeglasses can correct vision. A deaf child must be trained to listen to and recognize the sounds he hears through his hearing aid. Almost all deaf children have some remaining hearing and this residual hearing can be used.

SUGGESTIONS FOR PEOPLE WORKING IN THE NURSERY

1. Do not dominate children's play activities. Join with them in play and accomplish your goals as part of their activity. Initiate activity only with a child who seems to need help; or if you have planned a specific activity, begin it by your self and let the children gather around to participate as they will.

2. Be very consistent. A "NO" is to be definitely enforced and observed. Therefore, be careful and think several times before you impose a limit-- remember, with a deaf child it is extremely difficult (if not impossible) to explain "<u>This time</u> you may do it because . . . . "

3. Use distraction to control children's behavior, i.e., if two children are heading for the same toy, introduce another toy to lead one of them away. Also use distraction to remove a child from an undesirable activity. Anticipate trouble and "head it off at the pass."

4. In executing your activities, do not tire the children (or yourself). Remember that they need periods of rest, and that their attention span is limited. Do not be too elaborate and do not be afraid to improve on your plans.

5. Follow all the principles for aiding understanding:
   a. Get down on the child's level. Speak close to the microphone of his hearing aid.
   b. There are sounds and noises occurring around the child all the time. Be certain to respond to them by placing your hands to your ears and saying "<u>I</u> hear it!" If possible repeat the sound or noise and your response to it.
   c. Talk about things which are happening at the moment so that it will be meaningful to the child.
   d. Minimize gestures. Demonstrate to the child rather than gesture to him.
   e. Use complete and simple sentences when talking to the children. Try to avoid single words. Change your stress and inflection pattern--the pitch of your voice.
   f. If a child is babbling a sound as he is playing, babble the same sound along with him-again remembering to change the stress and inflection pattern of your voice.
   g. Use natural speech.

6. RELAX AND ENJOY THE CHILDREN: THEY'RE A LOT OF FUN!!!

THAYER LINDSLEY NURSERY

1. The Thayer Lindsley Nursery is a family-centered program which aims to help deaf children through parent education. It is our hope that the program will provide the parents with enough understanding of, and information about, the problems of deafness to enable them to face their decisions in the following years with confidence.

2. The Nursery is part of the Robbins Speech and Hearing Center of Emerson College, and is used also for teaching purposes. The techniques and philosophy of the program are taught to our students who participate in the program. Many of these students will eventually be in a position to help establish similar programs in other communities. In addition, many professionals in Massachusetts and surrounding states have observed and learned from our program.

3. The nursery was established in 1965 by a grant of $15,000 from the John Lindsley Fund, supplemented by funds from Emerson College. The Nursery was maintained by a grant from the Federal Government. Funds have also been donated by interested groups and persons in the community. Our current budget is obtained from Emerson College, entirely.

4. There are no fees for any of the services provided by the Nursery. This is to insure that all families have an equal opportunity to participate in the program regardless of financial status.

"HYPOTHETICAL FAMILIES"

Appendix D

Mrs. A. is very confused. She has taken her $2\frac{1}{2}$-year-old child, who is not talking and not seeming to respond to sound, to several doctors. Her family pediatrician has told her that he thought her child was deaf, but that nothing could be done until he was four. One physician has told her he thinks the child is mentally retarded. Her husband and in-laws, on the other hand, feel that there is nothing wrong with the child, and that he will "outgrow it." They tell her about the uncle who did not begin speaking until he was four years of age and is now perfectly all right. What should Mrs. A. do?

Mrs. B. sometimes says to her self, "Why did this happen to me." She has said, "I know I shouldn't feel this way, but I really resent having a deaf child. He takes so much of my energy and time. He is so difficult for me to control- I worry about him so much. Every now and then I find myself wishing for a moment that I had never had him, and then I feel guilty about feeling this way. I also hate to go out with him because of the screams he makes and the stares of passers-by when they see his hearing aid. I just can't stand any longer the questions of strangers and their well meaning advice." What can be done about these feelings?

Mrs. C. feels that her deaf child was given to her because of her past "sins." She has devoted herself to taking care of her child. She no longer goes out socially, and has dropped most of her friends. She spends a good part of the day working with her deaf child, and taking him to his therapy lessons. Evenings she spends reading and talking about deafness. She does not trust any baby sitters. Mr. C. has begun to complain about feeling "neglected" and he says he is concerned about the two older children who have not received much attention from their mother. What are your feelings about this family?

Mr. D. is a physician, whose father and grandfather were also doctors. He has always wanted to have a son who would be a physician also. Now that he has learned that his only child is deaf, and therefore, will never be able to be a physician, Mr. D. has not devoted much attention to the boy. He has said, "I had so many plans for him. Every time I see the hearing aid it reminds me that he won't be what I would like him to be, and it's really very hard for me to be with him. I know I shouldn't feel this way and it probably is harmful to him, but having a deaf son is a very big disappointment to me." What can this father do?

Mr. and Mrs. E. have three children. Their youngest is a 2-year-old deaf child. The other two are 6 and 10. The E's have been very busy taking the 2-year-old various places for evaluations, and have begun a twice weekly therapy program and lessons at home. The middle child has responded to his younger brother's problem very well, and in fact, seems more understanding of it than the oldest boy. The oldest child has reacted with a great deal of jealousy. He is extremely difficult to manage - throws violent tantrums and often simply withdraws for fairly long periods of time. Mr. E. has reacted to this by stiff disciplinary measures. Mrs. E's reactions have varied from anger to pleading and bribing. At the same time, she recognizes that neither she nor her husband are being effective in handling the 10-year-old. What might they do?

Mr. and Mrs. F. have a two-year-old deaf son. Mrs. F's parents live very near to them, and Mrs. Z. has not accepted the fact that her grandson is deaf and will "never" be able to hear. She keeps sending her daughter articles from newspapers and magazines about operations and cures for deafness. She is constantly urging her daughter to take him to "one more doctor." Mrs. F. says, "It is hard enough having to accept it ourselves, but it is especially difficult when we keep having to explain over and over again to them, and they don't really listen to us." Mr. F's parents, on the other hand, live further away and see their grandchildren rather infrequently. When they do see their grandson, they feel he should not be punished--"After all, he is deaf," and they become upset if either Mr. or Mrs. F. disciplines the deaf child in their presence. How could this family help to reduce some of these conflicts?

Timothy G. is a $3\frac{1}{2}$-year-old deaf, only child. He is not permitted outside the house unless accompanied by one of his parents, despite the fact that they live on a quiet suburban street. His mother is very concerned that he might be hit by a child on a bicycle, or hit by a car, because he can't hear. The parents are also afraid that he may fall down and hurt his ear or his hearing aid. Consequently, he seldom leaves the home or plays with children his own age. Should this situation be altered? Why? Why not? If so, what suggestions would you make to these parents?

Mr. and Mrs. H. live in a medium-sized town, forty miles from Boston. They have lived in the town all their lives; the father owns and operates a small business there. The parents own their home in the community and both are very active in community affairs. They have three children aged 10,8, and 5; the youngest of whom is deaf and has been accepted in a school for the deaf in a suburb near Boston. Because of the distance involved, the school will accept the child only on a residential basis. Rather than have her daughter board at the school, Mrs. H. wants to move to a community close to the school so that her daughter might attend on a day basis. Mr. H. is opposed to such a move; his feeling is that moving to the new community would disrupt the whole family. What should this family do?

Mr. and Mrs. I. find themselves at complete odds over the management of their deaf 3-year old son. Mrs. I is convinced of the worth of the aural/oralist approach and is trying to teach her son to lipread and communicate orally. Mr. I., on the other hand, is convinced that only a very small percentage of the deaf population ever attains reasonable oral communication and would prefer that his son learn manual communication, so that he at least can communicate with other deaf individuals with facility. Mr. I. is around his children very little, but whenever he is, he uses signs to communicate with his deaf son. What can these parents do?

Mr. and Mrs. J. have a 3-year old deaf child. The family lives on an island and because of the lack of facilities and professional help, Mrs. J. has had to teach her daughter by herself. The child is doing well; she lipreads about 30 words, responds very well on contextual cues, and uses about 15 words expressively. Mrs. J. has also placed her child in a nursery school with hearing children, where she does well. Mrs. J. has just been told that her daughter can begin attending a school for the deaf on the mainland, which means that the child can get home only every 4 to 6 weeks. What should she do?

THE FIVE FALLACIES

Appendix E

1. The fallacy of "It's Better Than Nothing" - This belief is held by the parent who accepts an inferior program because he feels there is no alternative. It should be borne in mind that when you place your child in a "deaf" program you are removing him from the orally stimulating and interesting environment of his home and neighborhood. THIS IS NOT "NOTHING!" And to give this up in order to participate in an inferior program could be a very serious error. Recently, the staff and a parent group interviewed a mother with a four-year-old deaf child, living in an isolated community. The child has never been seen regularly by a teacher of the deaf, nor has she ever received any formal tutoring, yet she has excellent communication skills, due in large part to a diligent, insightful parent and the highly oral environment of the home. Do not ever sell this short and, if you are going to give it up, be sure it is for a program that you are satisfied with and/or one that can in some way be worked with so as to be improved.

2. The fallacy of "Two is Better Than One and Three is Even Better Than Two"- Bringing your child to many different therapists can be quite harmful and confusing to both the child and parent. One therapist working against the goals of another therapist does not equal two, but rather can be educationally devastating. Tutors work very differently, and while they may have the same general goals, the specific steps and techniques can be totally different; two uncoordinated teachers are seldom any better than one. This is not to eliminate complimentary programs, e.g. a hearing nursery and tutoring, but it is necessary to concentrate on finding one good teacher and staying with her for a while.

3. The fallacy of "The Parent as a Teacher of the Deaf" - Despite the intensity of our program, it in no way trains a parent to be a teacher of the deaf. Even if the parent could qualify academically, she would be foolish to assume this role with her own child. Your child has but one mother, and you must never give up this maternal aspect; if at any time your tutoring interferes with your mothering, give up the tutoring. Furthermore, your child as he gets older, will need more specialized and "exotic" techniques that are beyond the scope of most parents. While we hope this program would enable you to intelligently supplement the school program, your main consideration is to supply a loving, oral home environment

in which your child can develop and grow to his full potential, happily and healthily.

4. The fallacy of "The Professional Always Knows Best"- Some of the educational decisions that must be made are extremely complex, and are not just a matter of your child's deafness or communication skills, but involve a great deal more regarding your family, your values and your life situation. Many of these things a professional cannot weigh for you. Professionals are to be consulted and their opinions considered, but final decisions must be yours--Parents, have the confidence of your judgments. Placement in a "wrong" educational situation is rarely harmful in the long run, if the parent is willing to keep abreast of the situation, has the confidence to admit that it is not satisfactory and has the courage to change it. Your mistakes can usually be corrected and your child will survive them (he has to!). What you must do is gather all the data while you can and make the best decision for your family. As one father put it, "Even if I make the wrong decision, I'd like to be sure it was for the right reasons."

5. The fallacy of "Letting George Do It"- There is the very real human tendency to sit back and let the "other guy do it." This tendency is enormously increased when you have found a satisfactory educational program for your own child. In Massachusetts, professionals have not always been alert or responsive to the needs of all deaf children, and parents have had to assume many roles and responsibilities that would not ordinarily be theirs. Parents must maintain a vigilant, "watch-dog" role to keep the programs growing. We have been enormously pleased at the large number of "Georges" who have come from our groups. Keep up the good work, and together we can affect profound changes in the education of deaf children

EVALUATION FORM

Appendix F

The following evaluation form is intended to help us improve our program. Please feel free to criticize any aspect of the program. All responses will be confidential.

What do you feel you have learned as a result of this program?

How well or how poorly do you feel the program met your needs?

What has been the effect of this program on your entire family?

What changes would you suggest?

Please comment about each aspect of the program and its value, if any, to you:

Nursery:

Tutoring:

Group Class:

Evening Meetings:

Has it been of any value to you to observe a hearing child in the nursery? How?

At present, what is your major concern regarding your child?

Name_____

Date_____

SECOND SEMESTER SCHEDULE

Appendix G

Group 1	9-23	9-30	10-7	10-14	10-21	10-28	11-4	11-18	12-2	12-9	12-16	1-6	1-13	FINAL CONFERENCES
Mrs. A	O	T	T	T	O	N	T	T	O	N	T	T	N	
Mrs. B	T	O	N	T	T	O	N	T	T	O	N	T	T	
Mrs. C	O	N	T	O	N	T	T	O	N	T	T	O	T	
Mrs. D	T	T	O	N	T	T	O	N	T	T	O	N	T	
Mrs. E	T	O	N	T	T	O	N	T	T	O	N	T	T	
Mrs. F	T	N	O	N	T	T	O	N	T	T	O	N	T	
Mrs. G	N	T	T	T	O	N	T	T	O	N	T	T	O	
Mrs. H	N	T	T	O	N	T	T	O	N	T	T	O	N	

N = Nursery

T = Therapy

O = Off

OE 6000 (REV. 9-66)

DEPARTMENT OF HEALTH, EDUCATION AND WELFARE
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ABSTRACT

800 Forty-eight families each having a pre-school deaf child were
801 enrolled in an intensive, two academic semester program. The program
802 was centered around the parent. The parent participated actively in
803 the therapy, nursery and group discussions. The parents were given
804 control over much of the program. Techniques such as having the
805 parent initiate therapy with another deaf child, including hearing
806 children in the nursery, use of the "Hypothetical Families" in
807 discussion were found to be helpful in promoting parent education.

808 Several problems noted by the staff included the pervasive middle-
809 class value system, the difficulty of orienting the staff and parents
810 to the parent-centered concept of the program and the lack of adequate
811 norms and measures of communication potential in young deaf children.

812 Nearly 75% of the graduates of the program, both parent and child,
813 were rated superior by classroom teachers of the deaf when compared
814 to non-alumni. Due to the lack of an adequate control group the
815 conclusion that the program was responsible for the superior
816 performance of the graduates was not tenable. The program, however,
817 did create a very active, community minded parent group which lobbied
818 for an obtained increased services and legislation to aid all deaf
819 children in the state. The program has been found to be compatible
820 with existing child-centered programs.

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